Adult Intake Form **CONFIDENTIAL**

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name:_____ Date of Birth_____ Age_____ Sex____

Present Address_____
Number *Street*

_____
City *County* *State* *Zip Code*

Phone: (_ _ _) __ __ __- __ __ __ __ Cell: (_ _ _) _ _ _- _ _ _ _ e-mail_____

Ethnicity_____ Years of Education_____ Referred by: _____

Marital Status: Single_____ Married_____(# of Years _____) Divorced_____ Separated_____

Presently Living With: Parents ____ Spouse ____ Roommate____ Alone___ Other_____

Occupation_____ Total Hours/Week_____

Employed by_____ Phone_____

Religious Affiliation_____ Church_____

Are you a member? Yes_____ No_____ Active_____ Inactive____

Family member to notify in case of emergency: Name:_____

Address:_____ Phone:_____

FAMILY MEMBERS

Relationship	Name	Age	Grade in School Last Completed	Occupation if Out of School
Spouse				
Father				
Mother				
Brother(s)				
Sister(s)				
Children				

Describe any physical problems you have that require medication or physical care: _____

_____

Are you currently receiving medical treatment? Yes _____ No _____

When did you last consult with your primary care physician? _____

Are you currently taking any prescription medications? Yes _____ No _____ If yes, please list by name and dosage: _____

_____

Previous Counseling/Therapy Yes_____ No_____ If yes, when?_____

With whom? Name _____Address:_____

_____

Briefly describe the problem which prompted you to seek counseling at this time: _____

_____

_____

_____

_____

Have there been times when the problem got better or disappeared? Yes _____ No _____

If yes, when? _____

What do you think helped? _____

_____

_____

Were there times when the problems were especially bad? Yes _____ No _____

If yes, when? _____

What made it bad? _____

_____

_____

Are there other people who play a major role in causing your problems or in helping you cope with your problems? Yes _____ No _____

Explain briefly: _____

_____

Is there anything else that you believe might be important for your counselor to know at this time? _____

_____

_____

_____

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

_____ Anger
_____ Depression
_____ Education
_____ Eating difficulties
_____ Fearfulness
_____ Nervousness
_____ Financial problems
_____ Marital problems
_____ Physical problems
_____ Problems with social relationships
_____ Problems with children
_____ Problems with parents
_____ Religious/Spiritual Concern
_____ Sexual Concerns
_____ Thoughts of suicide
_____ Trouble making decisions
_____ Unhappy most of the time
_____ Use of alcohol
_____ Use of alcohol by family member
_____ Use of other drugs
_____ Work
_____Worry
_____ Other (specify) _____

Signature _____ Date _____

For clients age 17 and under, the signature of his/her guardian or custodial parent is required.

Parent/Guardian _____ Date _____